

**COMPREHENSIVE DERMATOLOGY GROUP
PATIENT MEDICAL HISTORY FORM**

Date: _____

Name: _____ **DOB:** _____

Reason for Visit: _____

Allergies: _____

Current Medications (include prescriptions, over-the counter, vitamins, herbals):

Medication	Dose	Frequency	When started

Major Medical Illnesses/Surgeries:

Females: Are you pregnant? ___Yes ___No If Yes, when due _____
Are you planning to become pregnant? ___Yes ___No
Are you nursing? ___Yes ___No

Past Medical History/ Family History: Check if you or anyone in your family has:

	Self	Relative		Self	Relative		Self
Skin Cancer			Arthritis			HIV	
Melanoma			Autoimmune Disease			Hepatitis B or C	
Other Cancer			Bleeding disorder			Tuberculosis	
Eczema			Diabetes			Positive tb test (ppd)	
Psoriasis			Gastric Ulcer				
Keloids			High Blood Pressure				
			Thyroid Disease				

Current or Past Medical Problems With:

	Yes	No	If yes, please explain
General Health			
Allergy/Immunologic			
Eyes			
Ears/Nose/Mouth/Throat			
Heart			
Lungs			
Stomach/Gastrointestinal			
Kidneys/ Bladder			
Joints/ Arthritis/ Musculoskeletal			
Blood/ Bleeding Problems			
Blood Clot			
Neurological/ Headaches/ Seizure			
Psychiatric			
Other			

Social History:

Do you drink alcohol? ___ Yes ___ No If yes, drinks per day _____

Do you smoke? ___ Yes ___ No If yes, packs per day _____

If quit, what year _____

Have you ever used IV drugs? ___ Yes ___ No

Hobby/Leisure Activities: _____

Patient Signature: _____ Date: _____